Population Reports

SERIES E
NUMBER 2
NOVEMBER 1974

LAW AND POLICY

Department of Medical and Public Affairs, The George Washington University Medical Center, 2001 S Street, N.W. Washington, D.C. 20009

World Plan of Action and Health Strategy Approved at Population Conferences

Two population conferences—one in August 1974 and the other in September 1974—approved two far-reaching plans for population, development, and health programs over the next decade.

The World Population Conference, which was attended by representatives from 137 governments and held in Bucharest, Romania, August 19-30, 1974, adopted by consensus a World Population Plan of Action. Reflecting political as well as demographic pressures, the Plan of Action calls for socioeconomic development as well as health and family planning programs designed to reduce excess fertility. It endorses the basic human right of all couples or individuals to determine the number and spacing of their offspring and calls on governments to supply the information and means to make this right a reality.

The World Medical Association, in cooperation with the World Federation for Medical Education, the International Planned Parenthood Federation, and the World Health Organization, convened an international conference on The Physician and Population Change in Stockholm, September 4-6, 1974. This conference approved a Strategy for Action designed to mobilize physicians to help meet the new demands which have been placed upon all the health professions as a result of rapid population growth in much of the world.

Politics and Publicity in Bucharest

The Bucharest conference, attended by thousands of representatives of governments, international agencies, and private organizations, was highly publicized and strongly politicized. From the differing views and interests of developing and developed nations, of countries with very high and very low fertility and mortality, and of communist, capitalist, and mixed economic systems, a consensus emerged. In addition to increased development and decreased fertility, the Plan emphasized the need for higher status of women, improved health care services, research, training, and increased international support for all population related activities.

This **Population Report** reviews the achievements of two major international conferences on population and related issues as reported firsthand by P. T. Piotrow, Ph.D. The account of the Stockholm Conference is based on a summary prepared by Carl Taylor, M.D., Dr. P. H. and Henry van Zile Hyde, M.D. Frances G. Conn is Executive Editor.

The Stockholm Conference, by contrast, was attended by several hundred representatives of national medical associations, medical schools, and related organizations. It met quietly, with little politics and little publicity. Participants from 72 countries agreed that physicians must play a more active role in securing better health care for the entire community; that they must utilize more medical auxiliaries to make services fully available; and that family planning must be included in existing health services and also extended to reach rural populations. With little dissent and notable determination, the participating physicians heard and endorsed a new approach to health going far beyond the traditional doctor-patient relationship to include a broad area of social and community involvement.

What will come of these two conferences? Will the World Population Plan of Action serve its purpose of encouraging expanded national and international programs to check excess population growth? Will the health-oriented Strategy for Action succeed in mobilizing physicians and health personnel and in making family planning and related health services more accessible to the world's people?

Only time will tell. Neither task is quickly or easily accomplished, but both conferences have pointed the direction to be taken if the world is to avoid a further multiplication of hunger, poverty, disease, and despair.

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Population Reports is published bi-monthly at 2001 S Street, N.W., Washington, D.C. 20009, USA, by the Population Information Program, Science Communication Division, Department of Medical and Public Affairs of the George Washington University Medical Center and is supported by the United States Agency for International Development, P. T. Piotrow, Ph.D., Director. Application to mail at second class postage rates is pending at Washington, D.C.

BUCHAREST: A PLAN FOR POLITICAL ACTION

By any reasonable standard, the World Population Conference held in Bucharest, August 19-30, 1974, must be called a success. For the first time in history, representatives from 137 governments met officially to consider the problems of population growth, size, change and migration. For the first time in history, the attention of Ministers and Cabinet members was directed over a two week period not only to the national and international effects of population growth but also to the needs of individuals and families for improved conditions of reproduction. For the first time in history, a World Population Plan of Action was adopted to encourage governments to establish and implement active policies and programs to improve their demographic position (2).

These are considerable achievements. The World Population Conference, which included all member countries except South Africa, Saudi Arabia, and North Vietnam, was the largest United Nations conference ever held. Even though reports in the mass media stressed the controversies rather than the consensus, the fact remains that the World Population Conference in Bucharest did reach agreement on a far-reaching Plan of Action that was accepted by acclamation with only the Holy See dissenting.

Two years of extensive preparation for the Conference had drawn governments, voluntary organizations, and international agencies into lively interaction. Even before the Conference, preparations for it and for the World Population Year in 1974 had led many countries to review and revise their own laws and policies. In 1972, for example, the government of Mexico asked the UN Fund for Population Activities and the International Planned Parenthood Federation for help in incorporating family planning services into the national health program. At the Conference, Brazil announced a policy recognizing the basic human right to determine the number and spacing of children and the government's obligation to provide information and the means that may be required by families of limited income.

Two weeks of discussion at Bucharest, including more than 347 amendments and 47 votes, transformed the draft Plan of Action from a demographic working paper into a political action manifesto. Like any political document the World Plan of Action includes many points of view and more recommendations than are likely to be followed. Nevertheless, it is a good start.

Development and Human Rights

Two basic themes which are repeated throughout the Plan provide the conceptual basis for most of the specific recommendations. These may be taken directly from the text of the Plan of Action as follows:

> The explicit aim of the World Population Plan of Action is to help coordinate population trends and the trends of economic and social development. The basis for an effective solution of population problems is, above all, socioeconomic transformation (para. 1) . . . Policies whose aim is to affect population trends must not be considered substitutes for socioeconomic development policies, but integrated with those policies to . . . promote a more balanced and rational development (para. 2).

> All couples and individuals have the basic human right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so (para. 13f).

Many developing and developed countries, spurred on primarily by Algeria and Argentina, stressed the issue of development, the need to reduce the desperate poverty of many lands and peoples in order to achieve "a fundamental improvement in international equity" both within and among nations. Also there was a clear call for the reduction of wasteful consumption and the just distribution of resources throughout the world. In this sense the World Population Plan of Action became a Development Plan of Action with implications and recommendations going far beyond demographic issues of population size, rates of growth, and distribution.

National diversity and above all national sovereignty were emphasized. No one questioned that:

> The formulation and implementation of population policies is the sovereign right of each nation . . . to be exercised in accordance with national objectives and needs and without external interference . . . (para. 14).

Nations were urged, however, to take "into account universal solidarity in order to improve the quality of life of peoples in the world" (para. 14) and to recognize that "the growing interdependence among countries makes international action increasingly important for the solution of development and population problems . . ." (para. 14k).

In part because of this strong nationalism, the proposed language which set specific targets for reducing birth rates and extending population planning services to all persons by 1985 was replaced by more general language which left the initiative for such actions clearly with national governments. It is still expected that birth rates in the developing countries will fall from 38 per thousand to 30 per thousand by 1985 (para. 36).

At the same time, while some governments, especially in Africa and Latin America, showed little interest in the problems of global population growth—which at present rates is expected to produce over seven billion people by 2000—virtually all governments acknowledged the right of couples and individuals to regulate their own fertility and

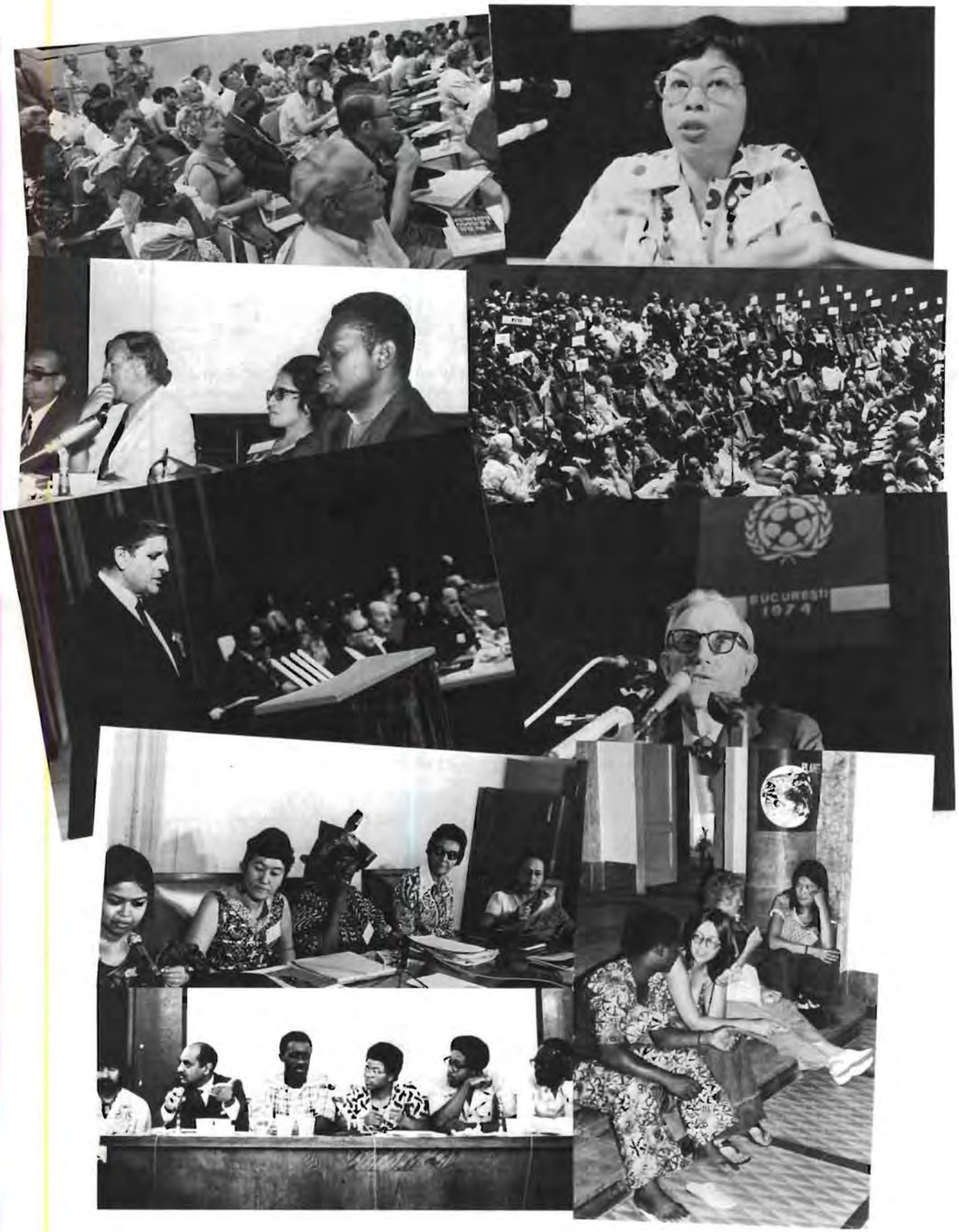

Fig. 1. Scenes from the World Population Conference, the nongovernmental Tribune and the Youth Conference at Bucharest, 1974

Fig. 2. Two prominent figures in Bucharest were (left) Dr. Antonio Carrillo-Flores, Secretary-General of the World Population Conference and former Foreign Minister and Finance Minister of Mexico and (right) Mr. Rafael Salas, Executive Director of the UN Fund for Population Activities (UNFPA) and former Cabinet Member in the Philippine government. Cartoons were drawn by Richard Wilson for the conference newspaper PLANET.

to have access to both the information and the means to assist them in practicing responsible parenthood. Even governments which seek higher birth rates, such as the Eastern European States, recognized this basic human right. In exercising this right, however, couples and individuals were urged to take "into account the needs of their living and future children, and their responsibilities toward the community" (para. 14f).

Status of Women Stressed

Closely related to human rights is the status of women. The Plan of Action includes forceful language on this issue recommending, among other points:

> the full participation of women in the educational, social, economic, and political life of their countries on an equal basis with men (para. 41).

Everyone recognized that in cultures where women are valued and honored primarily for child bearing, women will continue to bear many children. This language was adopted with little debate in a spirit categorized by one delegate as a paternalistic "Yes, dear" attitude. Nevertheless, for many women, who constituted less than 20 percent of the official delegations, "Yes, dear" was a substantial improvement over the traditional "No, dear." At least the language in the Plan of Action was a start toward further discussion and implementation during 1975, which the United Nations has designated as International Women's Year.

Despite extensive ideological and political debate on the background, principles, and objectives of the Plan, many specific recommendations for action were adopted without major change. These called for improved health and social services for rural as well as urban areas and for women as well as men; extension of family planning services; reduction of involuntary sterility, subfecundity, defective births and illegal abortions; increased attention to the needs of migrants; expanded administrative and substantive training, education, communications and information programs; and further research in social, economic, biological, medical, and demographic aspects of population.

Countries were urged to:

> encourage appropriate education concerning responsible parenthood and make available to persons who so desire advice and means of achieving it (para. 29b).

The broad thrust of many recommendations is reflected in the following section, offered by the host government, Romania:

> It is recommended that countries wishing to affect fertility levels give priority to implementing development programmes and educational and health strategies which, while contributing to economic growth and higher standards of living, have a decisive impact upon demographic trends, including fertility. International cooperation is called for to give priority to assisting such national efforts in order that these programmes and strategies be carried into effect (para. 31).

Plea for Increased Aid

Unlike many United Nations conferences, the Bucharest Population Conference did not call for a new organization but essentially reaffirmed the coordinating role of the UN Fund for Population Activities and urged it to cooperate closely with governments, UN agencies, and international nongovernmental organizations. To date 65 donors have contributed to the UNFPA which has supported more than

SUMMARY OF THE WORLD POPULATION PLAN OF ACTION

The World Population Plan of Action is a "policy instrument" of the international community "for the promotion of economic development, quality of life, human rights, and fundamental freedom."

Chapter I, Background to the Plan, affirms that "the basis for an effective solution of population problems is, above all, socioeconomic transformation" (para. 1). "In many parts of the world, poor economic conditions, social norms, and either inadequate knowledge of effective methods of family regulation or the unavailability of contraceptive services result in a situation in which couples have more children than they desire or feel they can properly care for" (para. 6). Thus population growth trends are out of balance with social, economic, and environmental factors, especially in developing countries where the decline in mortality has not been accompanied by a parallel decline in fertility. "As a result, the world population growth rate has risen to two percent a year. If sustained, this will result in a doubling of the world's population every 35 years" (para. 3).

Other population problems include infertility, rapid urbanization, migration, the high proportion of youth in countries with high fertility, and the high proportion of persons 65 and over in countries with low fertility. Because of demographic inertia based on age structure, countries are urged to anticipate future trends and undertake appropriate actions well in advance (para. 6,8,13).

Chapter II, Principles and Objectives of the Plan, emphasizes national sovereignty and the responsibility of national authorities for population policies and programs. Additional principles stressed are: the close interrelationship of population and development; the basic human right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so; the right of women to complete integration in the development process; the need for just distribution of resources and minimization of waste. Basically the Plan aims to improve national understanding and implementation of population policies, backed by increased international support.

Chapters III and IV include the following specific recommendations for action and implementation:

- Governments should develop national policies and programs relating to the growth and distribution of their populations, if they have not already done so, and the rate of population change should be taken into account in development programs. A high level government unit should be established to deal with population issues (para. 95).

- Developed countries should adopt appropriate policies in population, consumption and investment, bearing in mind the need for fundamental improvement in international equity (para. 19).

- Countries should aim at a balance between low rather than high death rates and birth rates (para. 18).

- Priority should be given to the reduction of high death rates. Expectation of life should exceed 62 years by 1985 and 74 years by 2000. Where infant mortality continues high, it should be reduced to at least 120 per 1000 live births by 2000 (para. 20-25).

- All countries should respect and ensure, regardless of their overall demographic goals, the right of persons to determine in a free, informed and responsible manner, the number and spacing of their children; countries should encourage appropriate education concerning responsible parenthood and make available to persons who so desire advice and means of achieving it (para. 29a, 29b).

- Family planning programs should be coordinated with health and other mutually supporting social policy measures designed to raise the quality of life and special attention should be given in all such programs so as to reach rural, remote, and underprivileged groups (para. 25, 30).

- To achieve the projected declines in population growth, birth rates in the developing countries will have to decline from the present level of 38 per 1000 to 30 per 1000 by 1985, which will require substantial national and international aid (para. 36).

- Countries which consider their birth rates detrimental to their national purposes are invited to consider setting quantitative goals and implementing policies to achieve them by 1985 (para. 37).

- Because the family is the basic unit of society, governments should assist families as far as possible (para. 39).

- Governments should ensure the full participation of women on an equal basis with men in the educational, economic, social and political life of their countries (para. 14h, 15e, 41-43).

- Policies should be developed to reduce the undesirable consequences of excessive migration and urbanization and to improve opportunities in rural areas and small towns, recognizing the right of individuals to move freely within their national boundaries (para. 44-50).

- International agreements should provide for the migration of workers and assure nondiscriminatory treatment and social services for these workers and their families and to decrease the "brain-drain" from developing countries (para. 51-62).

- Population censuses should be taken at regular intervals and information concerning births and deaths should be made available at least annually (para. 72-77).

- Research should be intensified to develop knowledge concerning social, economic, political, institutional, and legal interrelationships with population trends and policies; effective means for the improvement of health; new and improved methods of fertility regulation to meet the varied requirements of individuals and and communities; the interrelations of health, nutrition and reproductive biology; and methods for improving the administration, delivery and utilization of social services, including family planning services (para. 78-80).

- Training, education, and information programs should be strengthened in all fields related to population including management and administration (para. 81-92, 102).

- International, intergovernmental and nongovernmental agencies and national governments should increase their assistance in the population field on request and cooperate in program implementation (para. 96, 100-106).

- The Plan of Action should be closely coordinated with the International Development Strategy for the Second United Nations Development Decade, reviewed in depth at five-year intervals, and modified as appropriate (para. 107-109).

950 different projects affecting 92 countries (1). The Fund currently anticipates that $300 million will be required during the next four years, 1974-1977, to meet the increased program needs in developing countries. Of this, over 40 percent will be in support of family planning delivery systems. The Plan of Action notes that:

> considerable expansion of international assistance in the population field is required for the proper implementation of this Plan of Action (para. 104).

The Plan concludes by recommending that population trends and policies be monitored continuously with "a comprehensive and thorough review and appraisal of progress" by the United Nations system every five years with appropriate modifications (para. 107, 108).

In addition to agreement on the World Plan of Action as revised by a special Working Group, three committees met on Population Change and Economic and Social Development; Population, Resources, and the Environment; and Population and the Family. The committees approved resolutions, some of which contained even stronger, more specific language. For example, the urgent need to correct current imbalances between population growth and food, fertilizer, and nutrition needs was barely mentioned in the Plan of Action but included in several committee resolutions. In concurrent plenary sessions, virtually every government spoke, outlining domestic policies and frequently offering to provide assistance and/or share experience with others.

While the governmental meetings were in session, a Population Tribune made up of nongovernmental agencies and experts was also underway in Bucharest. To the subjects on the formal agenda at the conference, the Tribune added abortion, new developments in contraception, radical change in the position of women, anti-Malthusianism, pro-Malthusianism, information systems, and a wide variety of other questions. Earlier a youth conference had emphasized the interests and conflicts of the younger generation in considering fertility control.

Clearly, the principal division of opinion in all the debates at Bucharest was between those who urged that more attention be given to reducing birth rates in order to accelerate overall development and those who urged that more attention be given to overall development in order to reduce birth rates. Somewhat like medieval theologians arguing "Which comes first, the chicken or the egg?" some delegates emphasized ideology more than biology.

At the same time, however, there was a reluctance on the part of many countries to acknowledge that rapid population growth could seriously retard socioeconomic development. Both China and India, for example, despite their long-term and extensive family planning programs, did not argue for substantially increased efforts along these lines but rather stressed the need for overall development assistance. Thus the final version of the Plan conveys an optimistic note, with less urgency about reducing global population growth and providing individuals with the information and means to control fertility than was reflected in preliminary drafts.

To achieve the broad objectives that were endorsed will not be easy. To implement the Plan even on a limited basis will require high government priority, increased assistance from developed countries, and hard work from all those involved in the broad fields of population and development. The Plan is no substitute for action but rather a significant call to action that the world cannot afford to ignore.

Fig. 3. A noteworthy and popular feature of the World Population Conference and Tribune was the daily conference newspaper PLANET, written and edited by professional journalists under the direction of the International Planned Parenthood Federation.

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STOCKHOLM: A STRATEGY FOR HEALTH

Responding to the challenge from Bucharest, 450 physicians and population experts from 72 countries participated in the international conference on The Physician and Population Change, held in Stockholm, September 4-6, 1974. The conference was convened by the World Medical Association in cooperation with the World Federation for Medical Education, the International Planned Parenthood Federation, and the World Health Organization, following two years of preparation. His Majesty Carl XVI Gustaf of Sweden attended the closing session of the conference for which the Swedish Medical Association was host.

The role of the physician is a crucial one, the participants at the conference agreed, in helping individuals and communities adjust to current demographic challenges. After several days of discussion led by four panels of experts, a Strategy for Action was adopted. The strategy focusses on the four crucial roles in which physicians can affect demographic trends and improve the quality of life, especially in developing areas:

- as practitioners and family counselors
- as teachers and educators
- as research scientists and
- as community leaders.

Dr. Jose Felix Patino, of Colombia, Executive Director of the Pan American Federation of Associations of Medical Schools, set the tone of the conference in his opening statement that "overpopulation has become **the** most important factor affecting the health of mankind."

Social Issues Are Critical

The first panel, under the chairmanship of Dr. Clifford A. Pease of the Population Council, examined the role of curative and preventive medicine in influencing population trends. Whereas medical findings and technology helped to cause the dramatic decline in death rates which has greatly contributed to population growth, the widespread application of this technology received its major impetus from social and economic forces beyond the physician's control. Today physicians find themselves in the role of the sorcerer's apprentice, unable to hold back the flood of population growth they helped to initiate. The desire to live and be healthy is instinctive and universal, constituting an irresistible force in combatting mortality. The desire to limit procreation, on the other hand, is affected by other forces not yet fully understood. This is the challenge faced by physicians and others concerned with population change.

The panel emphasized that, whereas physicians have a key role in developing new technology for the management of fertility, the application of such technology is a legitimate concern of the whole community. Physicians must therefore work within the socioeconomic and cultural framework of the community, but they must not be passive or silent. In the words of one speaker, "Physicians have been acting like sheep; we must now roar like lions."

Benefits of Family Planning

Under the chairmanship of Dr. Frederick T. Sai of Ghana, Assistant Secretary General of the International Planned Parenthood Federation, the second panel focussed on the well proven effects of family planning in substantially reducing health risks for mothers and children and concluded that family planning should become part of routine patient care everywhere.

After lively discussion, participants agreed that the use of a particular fertility control method would depend on indigenous cultural, social, and legal considerations. Since the ideal contraceptive for all situations has not yet been—and may never be—developed, a combination of methods is required to meet the varying needs of individuals and couples.

Improvements in contraceptive technology—for example, laparoscopic female sterilization, menstrual regulation by uterine aspiration, colored condoms, improved three-month packaging for oral contraceptives, and possibly a combination vaginal contraceptive with venereal disease prophylaxis—will undoubtedly increase the number of family planning acceptors. Wider access to different methods through nonclinical channels wherever possible will also have an important impact on fertility, it was predicted.

There is increasing evidence, the physicians agreed, that health benefits of oral contraceptives are so much greater than health hazards that this method should be disseminated as widely as possible through every appropriate channel. This could be done, participants noted, with a minimum of professional supervision through community-based nonmedical facilities.

The changing legal status of abortion will require major medical adjustments in many countries. It is not right, several participants emphasized, that abortions be available only as a luxury for the rich or that contraception be available only for those with access to physicians.

Integrated Health Team Approach

The participants also agreed that health manpower could be better utilized through a team approach. Because most people in the developing world do not have access to a physician, it was suggested that trained auxiliaries are necessary to provide health services effectively and economically. Physicians should be ready to serve as consultants, teachers, promoters, and scientific researchers and should delegate responsibility and support auxiliaries who may subsequently become the real leaders in the community health teams. As one panelist commented:

> "In many developing countries a majority of the doctors are functioning where a minority of the population lives; more important, the most able men and women are not tackling the most difficult problems of health care delivery."

More should be learned about the best ways to integrate family planning with maternal and child health. This need not be an either-or proposition, Rapporteur Carl Taylor noted. Where maternal and child health services already exist, family planning should clearly be incorporated into these services. Where maternal and child health services are not now adequate—and this includes much of the developing world—family planning services should be made available immediately by the simplest possible means to serve the needs of those families already motivated but within the context of working simultaneously to develop the health infra-structure. In contrast to mass campaigns such as those for malaria or smallpox eradication, Dr. Taylor stressed that family planning requires continuing efforts and sometimes basic changes in thinking patterns and living habits. Whatever the first steps may be, integrated family planning and health services should be developed as rapidly as possible to assure stability, permanence, and continuing ability to meet the needs of the community.

Counselor-Client Relationship Urged

The third panel, led by Professor Alexander C. Turnbull of Oxford University, considered the attitudes of physicians toward fertility management. The consensus was that a new approach is needed. Family planning care is more appropriate to an egalitarian, voluntary counselor-client relationship than to the traditional doctor-patient relationship. In the final analysis, a family planning client must make his or her own choice of method and behavior. This requires counseling in clear and simple language by the physician and an effort to adapt medical services to the users' convenience. As one participant said, "Doctors should avoid projecting their own attitudes to the patients in the form of intrauterine neo-colonialism."

Physicians should offer hope and encouragement when justified and then should avoid raising unnecessary or misunderstood fears in those who seek family planning advice. As one panelist explained, "By exaggerated patient care procedures that produce fears, psychological barriers to family planning programs may be generated unconsciously."

Fig. 4. Stockholm demonstration of POPINFORM, the computerized population information retrieval system developed by the Population Information Program, George Washington University. Left to right: R. T. Ravenholt, USAID; H. Thykier, IPPF; H. K. Kolbe, POPINFORM (seated); P. T. Piotrow, POPINFORM; W. Boynton, USAID; C. Pease, Population Council.

Role of Medical Institutions

The fourth panel, under the joint chairmanship of Ghana's Dr. A. G. Boohene of the World Medical Association Executive Committee and Colombia's Dr. Jorge Villarreal of the Pan American Federation of Associations of Medical Schools, discussed the role of medical associations and institutions of medical education in population change.

The great potential of the academic medical center as the hub of education and training in health related spheres at all levels of sophistication was emphasized. Many such institutions, however, should redefine their objectives, taking into account the actual health problems in their areas as well as the demographic trends and realities. Research, too, should be related to the problems of the community served. Educational institutions should, in the view of the panel, provide all health personnel with an understanding of population dynamics and with training in contraceptive methods. The overall educational impact of such institutions should include making the people they serve aware of demographic factors that affect individual and community health.

Both the educational institutions and the national medical associations were urged to apply their intellectual resources and prestige to help shape local and national policies and programs related to population and increase the collaboration among teaching centers, practicing physicians and governmental health services. Medical schools were urged to establish departments of human reproduction that would encompass a broad range of biological and social disciplines.

Realistic Choices for the Future

Reflecting the sense of the conference, Dr. Taylor emphasized the need for greater realism in applying and adapting present technology to the requirements of different cultures and stages of development. He held out little hope of a sudden change in human nature or a dramatic, penicillin-like, technological breakthrough.

Although difficult choices must be made by physicians as they try to balance social good against individual good, excellence for a few against improvement for all, and political expediency against long-term development goals, Dr. Taylor cautioned against resignation or callousness. "In our role of physicians as leaders," he concluded, "we must have hope and we must radiate hope."

A draft "Strategy for Action" which had been developed by an Expert Advisory Group was unanimously adopted by the conference with a number of amendments. The text follows.

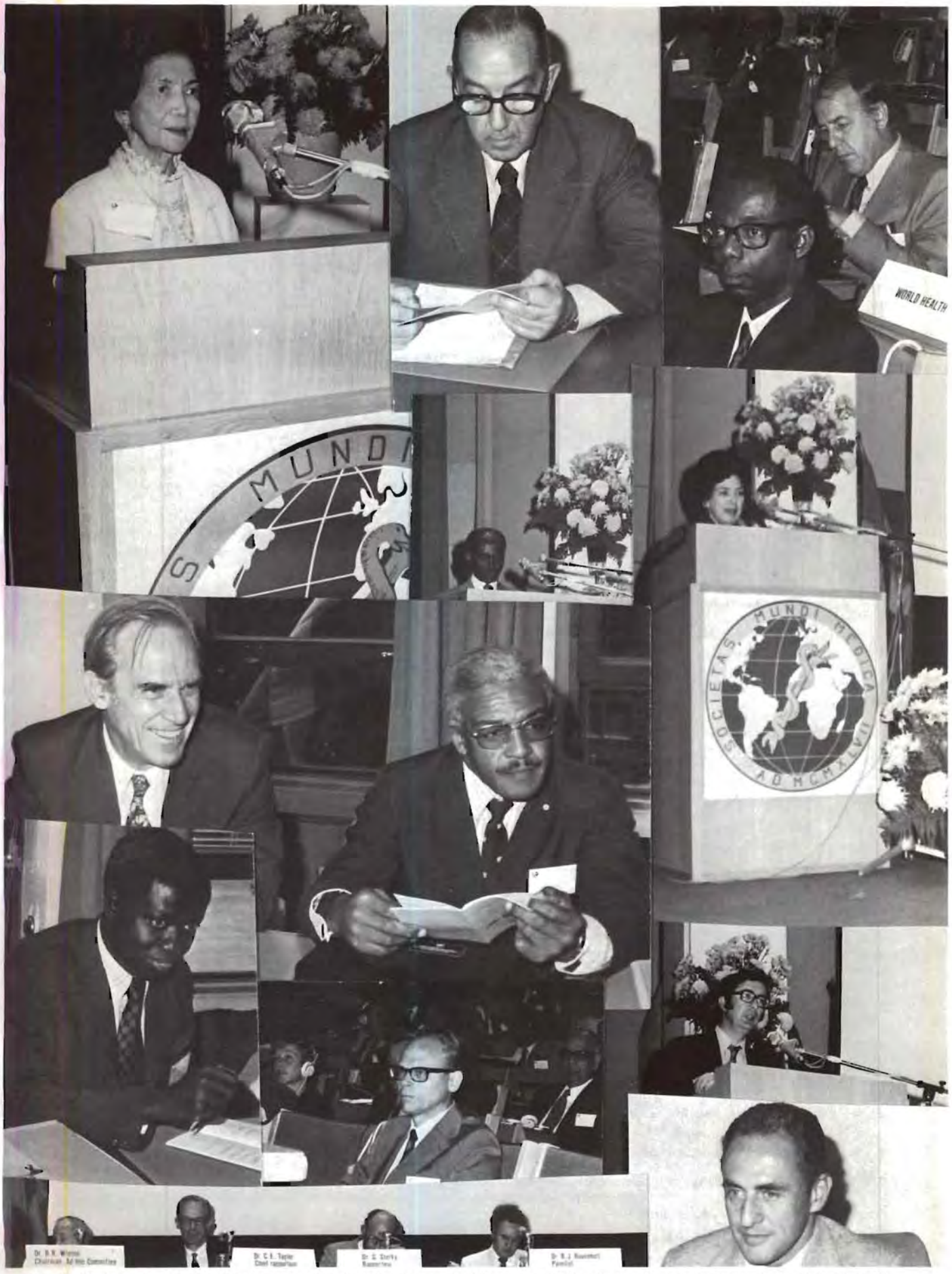

Fig. 5. Participants at the Stockholm international conference on The Physician and Population Change. Left to right, top to bottom: Drs. F. Del Mundo (Philippines); A. Santas (World Federation for Medical Education, Argentina); R. H. O. Bannerman (WHO); L. Kaprio (WHO); F. Sai (IPPF, Ghana); B. Stephenson (Canada); C. Taylor (USA); G. T. Cummins (IPPF, Barbados); A. G. Boohene (World Medical Association, Ghana); S. B. Nilsson (World Medical Association, Sweden); M. Potts (IPPF, England); R. R. Winton (World Medical Association, Australia); Taylor, G. Sterky (Sweden); R. T. Ravenholt (USAID); J. Villarreal (Colombia).

The Physician and Population Change

Growing worldwide regard for human welfare and development has contributed to recognition of the fact that changes in population size, distribution and composition must be subjects of concern to society. Physicians are becoming increasingly involved in programs which provide fertility regulating methods as one means of improving health and human welfare, and in trying to understand and interpret to others the many interacting issues relevant to population change. Important variations exist among countries in their demographic characteristics and in their understanding of population issues. These variations must be taken into account in the determination of approaches that are required for the resolution of the underlying problems.

The world is in a period of unprecedented demographic change, with population, at current rates of growth, doubling every thirty-five years. Many factors, including internal and external migration, contribute to population change; and this change itself influences the future of every society. One of the greatest forces of social change is the momentum of change itself. The magnitude and rate of population growth contribute significantly to this momentum. Population change cannot be understood or influenced, therefore, as an isolated phenomenon. As action programs are developed, they must be placed in the context of other activities, such as those in health, that improve the quality of life.

The basic reasons for introducing measures to regulate human fertility are: health, human rights and socioeconomic development. Interactions between health and fertility have become increasingly well-documented; and, as a consequence, the health reasons for fertility regulation are now widely accepted (3,4).

It is also widely accepted that social justice requires that all individuals and couples have, as a right, access to the information and the means enabling them to determine the number and spacing of their children. (See Summary of Plan of Action p. E-17) In exercising this right, individuals should take into account their responsibilities to society as a whole.

The socioeconomic consequences of rapid population growth, together with the desire to improve the quality of life, have led many countries to develop national policies and programs for fertility regulation. In some countries local conditions require primary emphasis to be placed on reducing mortality, morbidity and subfertility.

The physician has important roles to play in efforts to influence population change. Most obvious is the primary role of the health professions in reducing mortality and morbidity. Fertility regulation is an important and effective means of improving the health of mothers and children while at the same time, there is growing evidence that improved health contributes to fertility reduction. While the medical profession has rightly continued to concentrate on reductions in mortality, it has been slow to accept responsibility for fertility regulation. Particularly challenging is the broadening of the traditional role of the physician, as provider of individual patient care, to include participation in the solving of community health problems as part of improving the quality of life.

The physician must recognize that extension of health and fertility regulating services into the community will often require the use of other health personnel, working with physicians, as important members of the health care team.

This "Strategy for Action" outlines how the physician can most effectively contribute to resolving the problems associated with population change in his own time and place. A wide range of specific tasks are presented which will apply differently to each physician.

The medical profession has both the right and the responsiblity to lead rather than to follow in this increasingly important area of social change.

Principles

Physicians' activities in relation to population change can contribute to improvements in individual, family, and community health. Today's world demands more from physicians than ever before in this respect. Therefore, physicians require an understanding of:

1. the many complexities and interacting effects of population issues at the global, national, subnational, community, and family levels;
2. those factors, including fertility, mortality, morbidity, and migration that influence population change;
3. the social, economic, political, and religious aspects that may affect human fertility;
4. the important interrelationships between human reproduction and health;
5. the beliefs, attitudes, and life practices of the people with and for whom they work and the ability to identify with their aspirations; and
6. fertility regulating methods and services, their advantages and limitations.

The physician's role in fertility regulating services includes, inter alia:

1. planning, supervision and evaluation;
2. national, community and individual counseling;
3. education, training and research;
4. program monitoring and full membership in the health team; and
5. making fertility regulation services available to all who want or need them by promoting and supporting innovative delivery systems which make use of all appropriate community resources.

The Physician as a Practitioner and Family Counselor

Medicine as a profession has been greatly influenced by its practicing physicians. Their leadership largely determines the quality and availability of health care. When physicians become involved in an area of social change they constitute a potent force in the implementation of innovative programs.

Many organised medical bodies agree that all individuals and couples have the right to determine in a free, informed and responsible manner the number and spacing of their children. This means that information and education about fertility regulating methods, together with the means, must be available so that all couples can practise effective fertility regulation. Practising physicians can provide to all, regardless of age, number of children, or marital status, both the advice and the means of regulating fertility.

Furthermore, there is increasing evidence that too many pregnancies, too close together—particularly at the extremes of reproductive life—are associated with serious health hazards for the mother as well as for her children. It is, therefore, the responsibility of the physician to identify those women for whom a further pregnancy would carry increased risks to themselves or their children, and to prescribe for them safe, effective and acceptable methods for regulating future fertility. Decisions about methods depend upon what is legally permitted and upon what is acceptable to those concerned.

In accordance with these responsibilities, it should be recognized that:

1. all practising physicians, especially those dealing with mothers and children, must be familiar with the various methods of fertility regulation, their health benefits, and their short and long-term side effects and sequelae.* The physician should provide suitable follow-up and continuing care for couples and individuals using any method of fertility regulation. Reductions in numbers of children make their continuing care both more feasible and more important.
2. the laws and attitudes pertaining to abortion vary greatly from country to country. It is the physician's responsibility to ensure that medically adequate and socially humane services are available to women in accordance with local legal provisions and to provide all women who have had an abortion with counseling and adequate contraceptive services.
3. for some couples infertility or subfertility is as great a problem as unwanted pregnancy is for others. Physicians should provide appropriate investigation, treatment or referral for such problems.
4. the physician can help to educate both adolescents and adults in the processes of human reproduction and help them acquire a greater understanding of human sexuality. Physicians can also counsel individuals and couples in fertility regulating methods both before and during marriage.
5. in the world today, particularly in the developing countries, there is an acute shortage and maldistribution of health manpower and facilities, as well as the funds required to make fertility regulating information and means available to all who desire or require them. Physicians in both developed and developing countries should encourage the use of well-trained nurses, midwives, and para-medical personnel and support the employment of appropriate nonmedical channels in the provision of family planning information and services.

The Physician as a Teacher and Educator

The term "doctor" originated from the Latin *docere*, meaning "to teach". Physicians are teachers of undergraduate and postgraduate medical students, of other members of the health team, of their own patients, and informal instructors for their medical and other professional colleagues in community health matters.

As teachers of undergraduate and postgraduate medical students, physicians should promote innovation and continuing adaptation of curricula and teaching methods with attention to at least four areas relevant to population:

1. health aspects of population change, including the related issues of mortality, fertility, population movements, age structure and composition;
2. human reproduction and human sexuality in its biological and psychological aspects;
3. development, implementation, and evaluation of community programs for health and fertility regulation; and
4. education of medical students in the roles of other members of the health team so that proper delegation and reallocation of tasks and authority is ensured.

As a teacher of other members of the health team, the physician should emphasize practical training in the above four areas with consideration being given to the cultural and social milieu in which the team is working. The team should be trained in community organization, in methods of identifying high risk groups, in matters related to health and reproduction, and in monitoring side effects of fertility regulation methods.

The physician should recognize and carry out his responsibility to teach his patients and their relatives the health benefits of family planning and the availability, safety, and effectiveness of various fertility regulating methods.

The physician should also accept responsibility for educating medical and other professional colleagues about the health implications of population change, including scientific knowledge about fertility regulating methods. As a member of professional associations and institutions, he has particular opportunities to stimulate health and family planning action.

Physicians can be influential in community decisions. Their opinions are often solicited by community leaders and by the general public. Active involvement of the physician in discussions of issues related to fertility regulation can promote a rational and scientific approach to planning. To fulfill this teaching role, the physician should be skilled in the use of locally available communications media.

*Within national legal provisions and in accordance with cultural practices the following are the methods being used for fertility regulation: barrier and spermicidal methods, systemic contraception, intrauterine contraception, abortion, voluntary sterilization, abstinence and coitus interruptus.

The Physician as a Research Scientist

The tendency to view research as the prerogative of a select few has kept many physicians from serious involvement in investigations of problems related to fertility. In spite of general recognition of the significance of population issues, the field has yet to attract the number of career investigators that are required. Many unresolved problems would undoubtedly benefit from the active participation of physicians, particularly those with an interest in clinical research.

The physician as a research scientist can make important contributions to improving health, reducing morbidity and mortality, and regulating fertility. Research can lead to more informed and effective population, health, and social policies.

The following priority research areas should be considered as illustrative of the research possibilities existing in this field:

1. the general systems of health care as they affect reproduction, including the economics of health and fertility regulation delivery systems;
2. the interactions of health, health services, nutrition and population dynamics;
3. the physiology, psychology, biochemistry, pharmacology, and pathology of reproductive processes as they relate to medical and public health problems, including fertility regulation;
4. the development and study of new methods of fertility regulation, including their suitability in and acceptability to various population groups;
5. the problems of reproductive health and disease as they apply to such phenomena as menstruation, lactation, abortion, growth and development, and sterility;
6. the patterns of family planning practice in the community and services for family planning care;
7. the effects of various methods and procedures for the regulation of fertility and the treatment of sterility on the existing family and subsequent children;
8. health behavior and cultural factors that influence reproduction, including family planning;
9. clinical and epidemiological research into abortion and sterilization, with particular attention to their distribution, determinants, and long-term consequences;
10. incidence of reproductive wastage in relation to maternal age, parity, and the influence of other factors, such as nutritional status, in order to determine the optimum reproductive age in different population groups; and
11. operational research into the formulation, monitoring, and evaluation of different approaches to the provision of fertility regulating services. Research into manpower use and development should be part of these studies.

Physicians should recognize the interdisciplinary nature of research in the population field and especially the contributions that the biomedical and social sciences as well as managerial expertise can and do make. They should be prepared to work in cooperation with members of these and other disciplines.

Because of his status in society and his concomitant obligations, the physician frequently finds himself in a leadership role in areas relevant to population change. However, he should recognize that there are other disciplines that may be more important in given situations. In such cases the physician should be prepared to cooperate under other leadership.

The Physician as a Leader

The physician's leadership role may be viewed in three broad categories:

1. Opportunities in Community Leadership. The physician can exert leadership through example and by demonstrating his own values as they concern planned and responsible parenthood. In his community he can initiate and carry out programs for fertility regulation, introduce innovations as they become available, and assist in raising funds when necessary to carry out such programs. He can also supply leadership by helping to evaluate community population policies and programs and by accepting responsibility in organizations and agencies that are working on these problems. Finally, he can exercise leadership in the community by persuasion through the use of the available channels of communication.

2. Leadership in the Health Team. Leadership is especially needed to ensure the smooth functioning of comprehensive care teams that provide integrated health and fertility regulating services. As the usual leader of the health team, the physician must display managerial skills, acquire the ability to work with other community agencies, delegate routine responsibilities, develop regionalized networks for referrals, and monitor and supervise the services.

3. Leadership in Organized Health Services and Agencies. Physicians are involved at all levels of the health infrastructure of governmental and private agencies and institutions. In many communities, professional associations and voluntary agencies are influential channels through which physicians can exert collective leadership in health and population-related activities.

At the national level leadership in influencing population issues can be exercised by physicians with expertise in health planning, administration, evaluation and research. Close working relationships are needed with legislators, development planners, political and religious leaders, and public officials of all kinds.

At the international level, physicians also have leadership opportunities through their involvement with multilateral and bilateral foreign assistance agencies, intergovernmental agencies, and voluntary international and professional organizations. Tact and diplomacy in cross-cultural efforts are prerequisites to effectiveness. The physician should be prepared to express freely his views on population and related matters in local, national or international forums with his object being always the enhancement of the health and social well-being of mankind.